STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G010	A. BUILDING _____ B. WING _____	09/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCI-BURKE ICF/MR GROUP HOME	101 STEPHENS DRIVE MORGANTON, NC 28655

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: The facility failed to assure 2 of 4 sampled clients (#2 and #3) were taught to administer their own medications as evidenced by observations, interviews and record verification. The findings are: A. Client #2 was not taught to administer his own medication during the observed morning medication pass on 9/21/21. For example: Morning observations in the group home at 8:45 AM revealed client #2 receiving his morning medications with the assistance of staff A. Client #2's six medications were noted to be prepackaged by the pharmacy in a single bubble pack which was punched into a cup by staff A. The only participation by client #2 was for the client to retrieve the medication box from the cabinet, take his medications with water and return his water cup to the kitchen sink. Further observations revealed no training was provided for client #2 to learn about his medications, their side effects, or learn how to increase the self-administration of his medications. Interview with staff A revealed it is difficult to account for all of the pills in each of the clients' bubble packs due to the number that each one contains. Continued observation of the medication pass revealed staff took the needed	W 371	QP (Deven Bollinger), RN (Amy White) and Facility Administrator (Patti Holland-Corpening), will complete an in-service with all group home staff on how to assist clients in becoming more independent on self-administration of medications. Each client will be observed during medication administration and an appropriate self-administration goal will be added to the client's ISP. Each goal will contain details of how to assist and train the client's to be as independent as possible. The RN, QP and Facility Administrator will complete weekly observations of medication administration and provide hands on training as needed in this area	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Sherra Lackey, BA/QP | Executive Director | 9.30.21

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 371	Continued From page 2 pack which was punched into a cup by staff A. The only participation by client #3 was for the client to retrieve the medication box from the cabinet, take her medications with water and return her water cup to the kitchen sink. Further observations revealed no training was provided for client #3 to learn about her medications, their side effects, or learn how to increase the self-administration of her medications. Interview with staff A revealed it is difficult to account for all of the pills in each of the clients' bubble packs due to the number that each one contains. Continued observation of the medication pass revealed staff took the needed time to double check the pills in the pack with the pill descriptions on the label and the MAR. Further interview with staff A revealed she has not been trained on how to train any of the clients in methods to increase their self-administration of medications. Observations of client #3 throughout the 9/20-21/21 survey, substantiated by review of client #3's PCP dated 2/4/21, revealed the client to be very verbal and loves to carry on in conversation. Further review of the PCP noted client #3 "should be encouraged to participate as much as possible in taking her medications." Continued review of the PCP revealed the client's program for learning self-administration of medications was discontinued in 2019 after the client was diagnosed with Alzheimer's. However, no training was completed during the medication pass on 9/21/21 to help the client maintain her current skills, keep her active and possibly delay a decline in her functioning ability.	W 371		